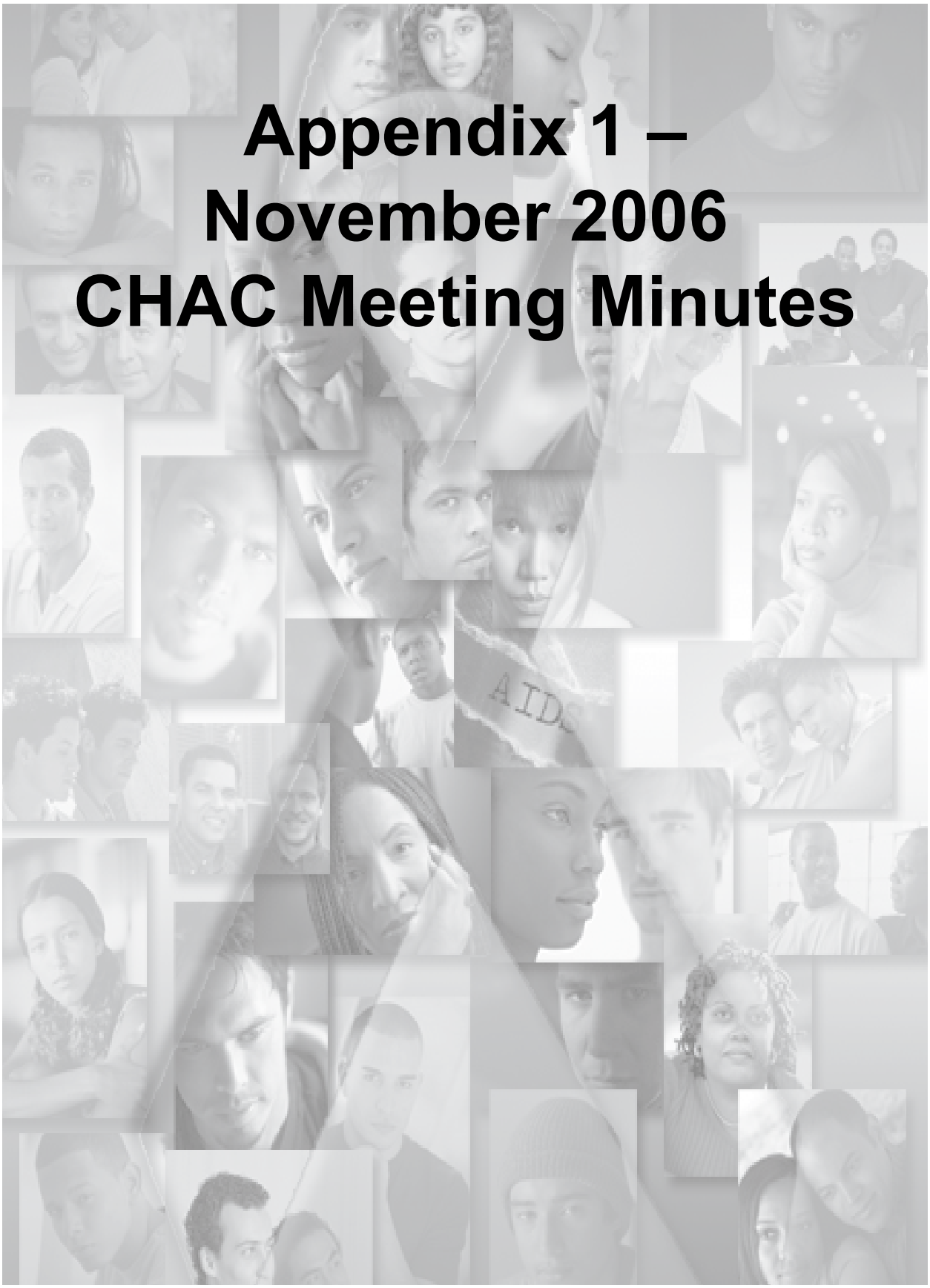
Appendix 1

Appendix 1 – November 2006 CHAC Meeting Minutes



Department of Health and Human Services
Centers for Disease Control and Prevention
Health Resources and Services Administration

CDC/HRSA Advisory Committee on
HIV and STD Prevention and Treatment
November 13-14, 2006
Washington, DC

DRAFT Record of the Proceedings

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Attachment 1
List of Participants

CHAC Members

Dr. Jean McGuire, Co-Chair
Mr. Jesse Milan, Jr., Co-Chair
Ms. Renee Austin
Dr. Dorothy Brewster-Lee
Ms. Theresa Devlin
Dr. Fernando Garcia
Rev. Debra Hickman
Dr. Edward Hook III, M.D.
Mr. Thishin Jackson
Dr. Dennis Leoutsakas
Mr. Thomas Liberti
Dr. John Martin
Dr. Judy Goforth Parker
Dr. Donna Sweet
Dr. Lydia Temoshok
Dr. Carmen Zorrilla

CHAC Ex-Officio Representatives

Dr. Pradip Akolkar (FDA)
Mr. Christopher Bates
(HHS Office of HIV/AIDS Policy)
Ms. Beverly Watts Davis (SAMHSA)
Mr. William Grace (NIH)

Designated Federal Officials

Dr. Kevin Fenton (CDC)
Dr. Deborah Parham Hopson (HRSA)

HHS, CDC and HRSA Representatives

Dr. Laura Cheever
Ms. Janet Cleveland
Ms. Holly Conner
Dr. John Douglas, Jr.
Dr. Hazel Dean
Ms. Teresa Durden
Mr. Michael Evanson
Ms. Paulette Ford-Knights
Dr. Fernando Garcia
Ms. Shelley Gordon
Dr. Robert Janssen
Ms. Amanda Jonas
Ms. Faye Malitz
Mr. Jose Morales
Dr. Douglas Morgan
Mr. Michael O'Rourke
Ms. Amy Pulver
Dr. George Roberts
Ms. Idalia Sanchez
Ms. Margie Scott-Cseh
Ms. Adelle Simmons
Mr. Stephen Smith
Dr. Howell Wechsler
Dr. Steven Young

Guest Presenters and Members of the Public

Ms. Deborah Arrindell (American Social Health Association)

Mr. Sean Barry (Community HIV/AIDS Mobilization Project)

Mr. Matthew Brenner (National Association of County and City Health Officials)

Ms. Kenisha Brooks (The Hidden Garden at ParkWest Health)

Ms. Diana Bruce (AIDS Alliance)

Mr. Luigi Buitrago (Washington, DC Administration for HIV Policy and Programs)

Ms. Kimberly Carbaugh (Association of Nurses in AIDS Care)

Ms. Audrey Chan (Association of State and Territorial Health Officials)

Ms. Holly Conner (Public)

Mr. Bo Cumbo (Gilead Sciences, Inc.)

Dr. Fabian Eluma (Substance Abuse and Mental Health Service Administration)

Ms. Donna Gallagher (New England AIDS Education and Training Center)

Mr. Michael Gipson (Washington, DC Administration for HIV Policy and Programs)

Dr. Laura Hanen (National Alliance of State and Territorial AIDS Directors)

Dr. David Holtgrave (Johns Hopkins Bloomberg School of Public Health)

Ms. Rachel Jankowski (AIDS Alliance)

Ms. Jennifer Kates (Kaiser Family Foundation)

Ms. Linnea Laestadius (MayaTech Corporation)

Mr. Nathan Linsk (University of Illinois-Chicago)

Dr. Marsha Martin (Washington, DC Administration for HIV Policy and Programs)

Ms. Deborah McKinney (National Minority AIDS Council)

Ms. Suzanne Miller (The AIDS Institute)

Ms. Asua Ofosu (National Association of Social Workers)

Mr. Murray Penner (National Alliance of State and Territorial AIDS Directors)

Mr. Nestor Roche (Washington, DC Administration for HIV Policy and Programs)

Mr. Carl Schmid (The AIDS Institute)

Mr. Greg Smiley (American Academy of HIV Medicine)

Mr. Shepherd Smith (The Institute for Youth Development)

Ms. Thelma King Thiel (Hepatitis Foundation International)

Ms. Sara Thomas (Sexuality Information and Education Council of the United States)

Ms. Evelyn Tomaszewski (National Association of Social Workers)

Ms. Josefina Valdez (AIDS Action)

Ms. Shay Welch (Public)

Mr. Guy Weston (Baltimore Eligible Metropolitan Area)

Dr. David Wiley (Texas State University)

Ms. Jen Heitel Yakush (Sexuality Information and Education Council of the United States)

Ms. Jamie Zamora (AIDS Action)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
HEALTH RESOURCES AND SERVICES ADMINISTRATION

CDC/HRSA ADVISORY COMMITTEE ON HIV AND STD PREVENTION AND TREATMENT
November 13-14, 2006
Washington, DC

Draft Minutes of the Meeting

The Department of Health and Human Services (HHS), Centers for Disease Control and Prevention (CDC), and Health Resources and Services Administration (HRSA) convened a meeting of the CDC/HRSA Advisory Committee on HIV and STD Prevention and Treatment (CHAC). The proceedings were held at the Hotel Washington in Washington, DC on November 13-14, 2006.

Opening Session

Dr. Jean McGuire and Mr. Jesse Milan, Jr., the CHAC co-Chairs, called the meeting to order at 8:42 a.m. on November 13, 2006. They welcomed the attendees to the proceedings and opened the floor for introductions. The list of participants is appended to the minutes as Attachment 1.

Dr. McGuire and Mr. Milan informed CHAC that they sent a letter to Dr. Ronald Valdiserri, the former Designated Federal Official (DFO) for CDC, to formally acknowledge his years of dedicated service to CHAC.

HRSA Update

Mr. Stephen Smith, Senior Advisor to the HRSA Administrator, covered the following areas in his report. HRSA observed the 15th anniversary of the Ryan White Comprehensive AIDS Resources Emergency Act (CARE Act) during its grantee conference in August 2006. The conference served as a time of remembrance, renewal and re-commitment. The grantees reflected on the significant amount of progress that has been made in treating the HIV/AIDS epidemic, such as collaborations with CDC on the HIV testing recommendations. The grantees also acknowledged that these efforts must continue to achieve greater progress in the future.

The pending bill on reauthorization of the CARE Act reflects the Administration's themes, including HIV counting, core services, better coordination among CARE Act Titles, and improved accountability. These themes are consistent with the President's principles of serving the neediest first and better targeting of resources. The CARE Act has not been re-authorized to date, but HRSA will continue to implement the current law and support the reauthorization process as opportunities arise. After the reauthorization bill is passed, HRSA will make diligent efforts to ensure that grantees have all necessary information and guidance to implement the new provisions.

HRSA is pleased that the President's FY'07 budget request includes an additional $95 million for new activities under the domestic HIV initiative. The House and Senate marked up the President's budget with different proposed budgets. HRSA and all other federal agencies are operating under a continuing resolution through November 17, 2006. HRSA will continue to monitor the current Congressional session on the HHS appropriation for FY'07, but significant changes from the President's budget request are not anticipated.

HRSA is continuing its analysis of 2005 CARE Act data in preparation of completing a final report. Preliminary results of the data analysis showed that CARE Act-funded service providers served a total of 954,323 duplicated clients in 2005. Of these clients, >33% were women and >70% were persons of color. The >4.06 million visits for healthcare services that were reported in 2005 represented a 1% increase over the number of healthcare visits reported in 2004. CARE Act services currently reach >500,000 individuals.

HRSA will continue several ongoing activities and implement new initiatives in FY'07 to improve its ability to deliver HIV/AIDS care. Close collaborations with CDC on new HIV testing recommendations will be continued. Funding will be allocated to support a number of new initiatives under the Special Projects of National Significance (SPNS) grant program. Ten grants will be awarded under the SPNS jail-based initiative for grantees to implement and evaluate innovative methods for linking persons living with HIV/AIDS (PLWHA) who are incarcerated or recently released from local jails to primary medical care and ancillary services.

A new SPNS grant program totaling >$6.5 million will be implemented to support innovative oral healthcare for PLWHA. The SPNS Information Technology Networks of Care Initiative will award funds to support organizations that promote the enhancement and evaluation of existing electronic information network systems to serve PLWHA in underserved communities. The SPNS Case Management Initiative will identify case management models and services that are most important for improving access to and retaining patients in care.

The Minority AIDS Initiative (MAI) will fund five new projects from one to multiple years. The MAI activities will focus on (1) HIV care for women of color; (2) intervention strategies to help clinics retain patients in care; (3) an evaluation of MAI activities; (4) an assessment of the needs of tribal providers who serve American Indians/Alaska Natives in AIDS Education and Training Center (AETC) regions; and (5) a study on issues and barriers to increasing the capacity of health professions immigrants to provide HIV care in the United States.

HRSA established new resources to support its HIV/AIDS programs and activities. The TARGET Center is a new web site and help desk that will provide two major services. A centralized source will be available for CARE Act programs to obtain technical assistance. Grantees will be provided with a “virtual community” to learn about and share ideas. The National Perinatal HIV Consultation and Referral Service Hotline will provide three major services. Around-the-clock advice will be given on standard and rapid HIV testing in pregnancy. Consultation will be offered on the use of anti-retroviral therapy (ART) during pregnancy, labor and delivery, and the postpartum period. HIV-infected pregnant women will be linked to appropriate health care.

HRSA will undertake several efforts to improve the quality of its HIV/AIDS programs and activities. Client-level data and National Quality Center guidelines will be used to develop quality indicators for the HRSA HIV/AIDS Bureau (HAB) and HIV/AIDS care and services provided by grantees. Quality training, support and technical assistance will be provided to HAB staff and grantees. HRSA recently completed a quality initiative of AIDS Drug Assistance Program (ADAP) processes with eight Title II states. Most of the eight states showed significant improvements in the quality of ADAP outcomes. HRSA is now exploring strategies to widely disseminate the quality improvement models to all states.

HRSA will continue its global HIV/AIDS activities through the President’s Emergency Plan for AIDS Relief (PEPFAR). PEPFAR’s accomplishments to date include implementation of the HIVQUAL model in 142 hospital sites in Thailand and an expansion of the HIVQUAL model to Uganda, Namibia and Mozambique in FY’06. I-TECH implemented clinical mentoring in three new countries in 2006 and is currently providing clinical training in 25 countries. Training of rapid HIV testing in Namibia led to an increase in post-test counseling from 20% in 2005 to 66% in 2006. HRSA expects PEPFAR to continue to be supported as a $15 billion initiative over five years.

HRSA will continue to closely monitor Medicare Part D and the impact of the donut hole on clients who receive HIV/AIDS services under the CARE Act. The "donut hole" is the gap in coverage when no insurance for prescription drugs would be available. After total drug costs reach $2,250, a patient would pay an additional $2,850 out-of-pocket before coverage would continue under Medicare Part D. The donut hole will not affect ~70%-80% of Medicare beneficiaries living with HIV who qualify for low-income subsidies. Due to the high cost of ART, however, Medicare beneficiaries living with HIV who do not qualify for additional assistance would need to consider strategies to obtain lower drugs costs in the "catastrophic" coverage level.

HRSA informed grantees that ADAPs could assist with Medicare Part D costs and provide ART to clients affected by the donut hole. HRSA also advised grantees to encourage Medicare beneficiaries to contact state ADAPs to explore opportunities for assistance with the cost of ART. Medicare beneficiaries also have the option of considering Part D plans that have higher premiums, but provide partial coverage to compensate for or completely eliminate the donut hole. HRSA has not yet developed cost estimates of the impact of the donut hole on CARE Act grantees.

HRSA grantees in Alabama, Louisiana, Mississippi and Texas are still recovering from the devastation of Hurricanes Katrina and Rita. The most significant challenges of grantees in these states are tracking clients who were displaced, meeting CARE Act requirements and restrictions, and adhering to conditions of awards. HRSA will continue to closely collaborate with grantees in these states to overcome these barriers.

HRSA took several actions to improve its readiness to respond to emergencies. An Emergency Operations Center and "e-Room" were established to provide an electronic system to collect data from grantee project officers in all HRSA bureaus. The Office of Commissioned Corps Affairs (OCCA) was established in May 2006 to provide a centralized point for deployments and all other HRSA officer activities. OCCA will oversee implementation of the HHS Secretary's vision for a transformed Commissioned Corps to ensure that the future force is prepared to meet the nation's public health and emergency needs.

Mr. Smith thanked CHAC for its vital role in improving HIV/AIDS prevention, care and treatment throughout the nation and the world. He emphasized that the knowledge, experience and dedication of each CHAC member are invaluable to HRSA and HHS as future policies are established for HIV/AIDS care and treatment. He added that HRSA would continue to rely on CHAC's expertise, guidance and recommendations to inform this process in the future.

On behalf of CHAC, Mr. Milan thanked HRSA for developing innovative strategies to assist CARE Act grantees. He was aware that legislative barriers and resource constraints adversely impact HRSA's ability to administer its HIV/AIDS programs. Despite these challenges, however, funding for the new FY'07 projects illustrates HRSA's diligent efforts and continued commitment to ensure that constituencies represented by CHAC are served.

Mr. Milan also commended HRSA for playing a critical role in ensuring that CHAC's voice was heard during ongoing efforts to reauthorize the CARE Act. Most notably, CHAC's proposed definitions for core medical services and other recommendations are being considered in current legislative drafts.

Other CHAC members joined Mr. Milan in applauding HRSA for allocating funds to implement and support the new FY'07 activities, particularly the MAI and SPNS initiatives. However, several members expressed concerns about certain aspects of some of HRSA's HIV/AIDS activities.

- HRSA's new jail-based initiative does not reflect coordination with a similar activity that CDC previously conducted. Lessons learned, experiences and important findings from CDC's jail-based effort should be reviewed.

- The change in the CARE Act law will require HRSA to add HIV to the formula for distribution of Title I and II dollars in 2007. Clients who receive HIV/AIDS services under the CARE Act in states with no name-based reporting system will suffer adverse impacts as a result of this change. HSRA should provide technical assistance to help jurisdictions in converting to a name-based reporting system because some areas might require up to four years to make this transition.

- HRSA has not broadly communicated information on its new HIV/AIDS activities and resources. Most notably, many providers have no knowledge of HRSA's National Perinatal HIV Consultation and Referral Service Hotline.

- HRSA should made stronger efforts to assist grantees in assuring continuity of care to clients who would be affected by the Medicare Part D donut hole.

- HRSA has not clearly described its efforts to collect client-level data. Most notably, CHAC has no knowledge of whether these data reflect capacity issues at various sites or if this activity is coordinated with the Centers for Medicare and Medicaid Services (CMS).

Mr. Smith, other HRSA staff, and Dr. Deborah Parham Hopson, the HAB Director and CHAC DFO for HRSA, provided additional details about HRSA's HIV/AIDS activities in response to CHAC's comments, questions and concerns.

- HRSA is currently collaborating with CDC to coordinate its new jail-based SPNS initiative.

- HSRA will continue to implement the 2000 CARE Act legislation in the absence of reauthorization. HRSA will adhere to the change in the legislation to add HIV to the formula for distribution of Title I and II dollars by 2007. Only HIV data from jurisdictions with HIV reporting systems will be used. Only name-based data that have been accepted and certified by CDC will be used. AIDS data will be accepted

from states that do not have name-based HIV reporting systems. The change in the legislation will primarily affect the allocation of funds, but will not necessarily impact delivery of care to clients who receive services under the CARE Act.

- HRSA is conducting several activities in preparation for the change in the CARE Act legislation that must be implemented in 2007. In the absence of an FY'07 budget and reauthorization of the CARE Act, modeling is being performed to identify jurisdictions that will be affected. Communications with grantees about the change in the legislation were initiated in 2000 and will continue. Close collaborations with jurisdictions with no name-based reporting systems will continue. Assistance will continue to be provided to jurisdictions that lose CARE Act dollars each year to help these grantees to prioritize funds and assure continued delivery of essential services to patients. The House bill proposed a transition period for jurisdictions to convert to name-based reporting systems, but the Senate bill did not contain the same language.

- HRSA is identifying strategies for community health centers (CHCs) to provide care to persons with HIV. HRSA is aware that many care systems are currently at capacity and are unable to provide care to new patients.

- HRSA recognizes that some states, territories and eligible metropolitan areas will receive less funds under Titles I and II in 2007 compared to 2006 based on the President's FY'07 budget. Even with decreased funding, however, all jurisdictions will be held harmless in 2007 according to the law.

- HRSA is pleased that ADAP waiting lists were decreased from eight to four states: Alaska, Montana, South Carolina and West Virginia. HRSA will attempt to spread ADAP dollars in these four states to ensure continued delivery of services to Medicare beneficiaries living with HIV who would be impacted by the donut hole. However, many patients who are on ADAP waiting lists still receive medication through established relationships between ADAPs and Pharmacy Assistance Programs.

- HRSA took action on formal motions that CHAC passed during previous meetings. The HHS Secretary provided Congress with HRSA's data runs for consideration in developing draft proposals of the CARE Act reauthorization. HRSA convened several consultations with grantees on the severity of need index and is now identifying a more quantitative strategy to analyze these data under Title I supplemental dollars.

- HRSA will use its established mailing lists of AETCs, CHCs, grantees, special interest groups and other organizations to broadly disseminate information on its HIV/AIDS activities and resources. Articles about HRSA's National Perinatal HIV Consultation and Referral Service Hotline were recently published in peer-reviewed journals targeted to obstetricians/gynecologists and family practitioners.

- HRSA is conducting several activities to assess the capacity of grantees to report client-level data. At the next meeting, HRSA will provide CHAC with an overview of its ongoing efforts to collect client-level data from grantees.

Dr. Kevin Fenton, Director of the CDC National Center for HIV, Hepatitis, STD and TB Prevention (NCHHSTP) [proposed], reported that similar to HRSA, CDC has also taken several actions to assist jurisdictions in converting to name-based reporting systems. Since 1999, states and local jurisdictions have been strongly encouraged to undertake this effort. Specific guidance and technical assistance have been provided to states and local jurisdictions, including methods to implement name-based reporting and strategies to assure data quality.

Legislative reviews were performed to assist states and local jurisdictions in examining barriers to converting to name-based reporting systems. New approaches are now being explored for CDC to more rapidly complete the data certification process. However, CDC is currently facing two major barriers to its ongoing role in providing assistance to states and local jurisdictions that still have not made the transition to a name-based reporting system: (1) addressing the backlog of HIV/AIDS cases reported over the past 25 years and (2) capturing new diagnosed HIV/AIDS cases.

Mr. Milan concluded the session by asking CHAC to provide him or Dr. McGuire with suggestions on resource needs for HIV/AIDS treatment and care for FY'07 and beyond that should be recommended to HRSA or the HHS Secretary. He confirmed that any suggestions proposed by the members would be presented and considered as potential formal motions during CHAC's review of its business items on the following day.

CDC Update

Dr. Fenton covered the following areas in his report. Several reasons served as the basis for CDC to revise and release its HIV testing recommendations for healthcare settings in September 2006. Many HIV-infected persons access health care, but are not tested for HIV until symptoms are present. Effective treatment is available. Awareness of HIV infection leads to substantial reductions in high-risk sexual behavior. High levels of knowledge about HIV result in a decreased need for pre-test counseling. A great deal of experience with HIV testing is available, including rapid tests. Existing evidence is inconclusive about the benefits of prevention from typical counseling for persons who test negative

Key language from CDC's revised HIV testing recommendations is highlighted as follows. For adults and adolescents, routine and voluntary HIV screening should be provided to all persons 13-64 years of age in healthcare settings. Screening should not be based on risk. HIV screening of persons with known risk should be repeated at

least annually. Opt-out HIV screening should be offered with an opportunity for persons to ask questions and decline testing. HIV consent should be included with general consent for care.

Prevention counseling in conjunction with HIV testing in healthcare settings is not required. Patients who test positive for HIV should be linked to clinical care, counseling, support and prevention services. HIV-negative patients who are known to be at high risk should be advised of the need for periodic re-testing and offered or referred to prevention counseling. The recommendations are intended for all healthcare settings, but not for community-based organizations (CBOs) or other non-clinical settings.

Recommendations on referral to care were not changed from CDC's previous guidance. For example, CDC still recommends referrals or linkages to care for all HIV-positive persons. Physicians should initiate screening in low-prevalence settings. Continued screening would no longer be warranted if a jurisdiction demonstrated an HIV prevalence of <1/1,000.

For pregnant women, universal opt-out HIV screening should include HIV in the prenatal screening test panel. Consent for prenatal care should include HIV testing. A second HIV test should be offered to pregnant women in the third trimester who are known to be at risk for HIV or those who are in key jurisdictions or high HIV prevalence healthcare facilities. Opt-out rapid HIV testing should be offered to women with an undocumented HIV status during labor and delivery. ART should be initiated on the basis of a rapid HIV test result. Newborns should be tested if the mother's HIV status is unknown.

CDC will launch its new Adult Hepatitis B Vaccination (HBV) Initiative in 2007. New HBV recommendations will be published in the Morbidity and Mortality Weekly Report (MMWR) in November 2006 and will call for venue-based vaccination of adults. The new initiative will maximize previous accomplishments in hepatitis B elimination efforts in the United States and will also take advantage of new synergies that are now available across CDC programs as a result of the agency-wide reorganization.

Four key strategies will be highlighted in the Adult HBV Initiative: (1) prevent perinatal HBV transmission; (2) implement universal infant vaccination; (3) implement catch-up vaccination for all children and adolescents <19 years of age; and (4) vaccinate adults in groups known to be at risk for HIV. Vaccination programs played a tremendous role in the dramatic reduction of the incidence of acute hepatitis B in the United States from 1984-2004. However, targeted interventions are still needed because the decline in the incidence of hepatitis B has remained flat in certain subgroups over the past few years.

In addition to publishing the new HBV recommendations, CDC will also conduct other activities under the Adult HBV Initiative. Access to free adult HBV in the United States will be increased. States and local jurisdictions will be encouraged to use savings in the federal 317 program to purchase vaccine. Plans will be developed to direct vaccine to HIV, STD and other clinics with high hepatitis B prevalence.

Vaccination capacity will be strengthened in specific sites, jurisdictions and settings where HBV should be provided. A request will be made to support local HBV coordinators. Training and technical assistance will be provided to HBV providers. Vaccination programs will be evaluated and improved. Approaches will be explored to make intensive investments over the next five years to truly eliminate hepatitis B in the United States.

The CDC Global AIDS Program (GAP) is continuing its participation and investment in global AIDS initiatives through PEPFAR. PEPFAR represents the single largest U.S. government investment in global HIV/AIDS activities. GAP is serving as a leader in implementing a public health evaluation strategy to collect and aggregate data across PEPFAR programs. GAP is also engaged in ongoing efforts for the Department of State and U.S. Agency for International Development to more closely collaborate with countries and embassies to plan initiatives, report data, and promote one U.S. government investment of HIV/AIDS and other health issues in different countries in FY'07 and thereafter.

New programmatic initiatives will be incorporated into PEPFAR in FY'07 based on findings from initial activities. More emphasis will be placed on prevention for HIV-positive persons; the relationship between HIV and alcohol; gender inequalities in terms of access to care and quality of services; and prevention of vertical transmission of HIV.

CDC played a major role in two developments that occurred in 2006 regarding STDs. The Food and Drug Administration (FDA) licensed use of the quadrivalent human papillomavirus (HPV) vaccine in June 2006 in females 9-26 years of age. The HPV vaccine is effective against HPV types 6/11/16/18 and the prevention of cervical cancer, genital warts, and cervical, vaginal and vulvar pre-cancerous or dysplatic lesions.

CDC's expertise was instrumental in the Advisory Committee on Immunization Practices (ACIP) making final recommendations on the HPV vaccine in June 2006. ACIP recommended routine use of the HPV vaccine for females 11-12 years of age; initiation of the vaccination series beginning at 9 years of age; and catch-up vaccination for females through 26 years of years. ACIP's statement on the HPV vaccine will be published in the MMWR in the first half of 2007. Data on the efficacy of the HPV vaccine in males are expected to be released in 2007 or 2008.

CDC established several workgroups throughout the agency to continuously monitor the impact of the HPV vaccine through communications and evaluations of vaccine uptake, safety and impact. GlaxoSmithKline is expected to apply for FDA licensure of its bivalent vaccine for HPV types 16/18 in 2007.

CDC is continuing to provide guidance on financial issues related to the HPV vaccine. The catalogue price of the vaccine is $120/dose for the three-dose series. Negotiations are underway to establish CDC's contract price of $96/dose. The Vaccines for Children Program will pay for the cost of the vaccine at no cost to children <19 years who

meet the following eligibility criteria: Medicaid recipients, uninsured persons, Native Americans/Alaska Natives, or under-insured and vaccinated persons at participating federally qualified health centers and rural health clinics.

The Merck Patient Assistance Program can be used to pay for the cost of the HPV vaccine in the private sector for persons who meet the following eligibility criteria: persons >19 years of age, uninsured persons, and persons with an annual household income <200% of the federal poverty level. Efforts are underway for Merck to receive signed forms from applicants and complete the approval process for payment in less than 10 minutes.

CDC compiled the newest evidence to update and release its STD Treatment Guidelines in July 2006 for use as a standard protocol for STD treatment in the United States. Key language from the guidelines is outlined below:

- Additional focus on appropriate screening and treatment of STDs among men who have sex with men (MSM).
- More emphasis on the benefits of re-screening for chlamydia and gonorrhea.
- Recommendations for partner-delivered therapy for chlamydia and gonorrhea if other strategies to reach partners would not be likely to succeed.
- New recommendations for treatment of chlamydia in pregnant women.
- New treatment recommendations to reduce transmission of herpes simplex virus type 2 (HSV-2).
- Information on available new medications for treatment of trichomoniasis.
- An update on the HPV vaccine and its licensure.
- New evidence on the effectiveness of male latex condoms in reducing the risk of pelvic inflammatory disease, HSV-2, HPV and HPV-associated diseases.
- Stronger recommendations for HBV vaccination of unvaccinated adults seeking care in venues that provide services to high-risk adults.
- Stronger recommendations for routine HIV testing for persons seeking evaluation and treatment for STDs, including opt-out testing.

CDC used several venues to widely disseminate the updated STD Treatment Guidelines, including a publication in the August 4, 2006 edition of the MMWR, distribution of hard copies upon request, the availability of hard copies on the CDC web

site, a video podcast, user-friendly pocket guides and wall charts for a broader range of stakeholders, and presentations at multiple professional meetings.
At the center level, NCHHSTP will conduct several activities to support its FY'07 strategic imperatives. To "maximize public health impact," NCHHSTP will align staff, strategies, goals, investments and performance to maximize its impact on the health and safety of populations. NCHHSTP established three FY'07 priorities to support this strategic imperative. The elimination of TB, syphilis and perinatal HIV will be accelerated. The implementation of hepatitis B, HPV and other vaccine-preventable STDs will be enhanced. The incidence and consequences of HIV/AIDS, hepatitis C and STDs will be decreased, particularly in racial/ethnic minority groups and resource-constrained countries.

To "ensure accountability," NCHHSTP will sustain public trust and confidence by making the most efficient and effective use of investments in NCHHSTP. NCHHSTP established two FY'07 priorities to support this strategic imperative. Information about HIV, viral hepatitis, STD and TB prevention investments will be more easily and readily available to the public. Funding investments for HIV/AIDS, viral hepatitis, STD and TB prevention will be published on the NCHHSTP web site.

To "strengthen public health science," NCHHSTP will create and disseminate knowledge and innovations for persons to protect their health now and in the future. NCHHSTP established three FY'07 priorities to support this strategic imperative. Training will be provided to promote scientific excellence within NCHHSTP. The ethical framework for HIV, viral hepatitis, STD and TB research will be adapted and refined. Workforce development will be promoted through internal and external research funded by CDC and its partners.

To "provide leadership," NCHHSTP will leverage its unique capabilities, partnerships and networks to improve the health system. NCHHSTP established three FY'07 priorities to support this strategic imperative. NCHHSTP's governance relationships and strategic priorities will be clarified and implemented. Leadership will continue to be provided at both national and international levels to improve health outcomes related to HIV, viral hepatitis, STD and TB prevention. Meetings will be convened with federal partners to enhance collaboration.

To "promote customer centricity," NCHHSTP will market tools that persons desire and need to choose health. NCHHSTP established three FY'07 priorities to support this strategic imperative. Existing partnerships will be sustained and strengthened. New and non-traditional partnerships will be developed to enhance the prevention and control of HIV, viral hepatitis, STD and TB. A communications plan that delivers accessible and comprehensive health messages to partners and the public will be developed.

To "strengthen global health efforts," knowledge and tools developed by CDC and NCHHSTP will be extended to promote health protection around the world. NCHHSTP

established two FY'07 priorities to support this strategic imperative. The successful implementation of PEPFAR will be facilitated and supported. Collaboration with global surveillance, research and program partners will be fostered for the prevention and control of HIV/AIDS, viral hepatitis, STD and TB globally.

NCHHSTP established two new strategic imperatives that will be implemented in FY'07. For "workforce development," NCHHSTP will facilitate and support the CDC-wide diversity initiative, employee career development planning and cross-training to meet future human capital needs. NCHHSTP established three FY'07 priorities to support this strategic imperative. Collaborative efforts will be undertaken with the CDC Office of Diversity to disseminate information on diversity policies, actions and initiatives related to diversity issues and trends. NCHHSTP managers will be educated on available resources to assist in recruitment and retention of a diverse workforce. Existing NCHHSTP resources will continue to be used to support training and career development.

For "surveillance and strategic information," NCHHSTP will harmonize data collection, analysis and distribution. NCHHSTP established two FY'07 priorities to support this strategic imperative. A cross-divisional surveillance workgroup will be convened to identify opportunities to harmonize data collection. The feasibility of producing an integrated annual surveillance report on HIV/AIDS, viral hepatitis STD and TB in the United States will be explored.

In addition to the strategic imperatives, NCHHSTP will also place strong emphasis on two other areas to make substantial gains over the next few years. For "program collaboration and service integration," integrated services might include HIV, STD and hepatitis B and C counseling and testing (C&T); partner services and referrals to additional prevention or care; and hepatitis A and B immunization. Integration will be focused at the field or client level where the interface between the system and the consumer occurs. For purposes of this strategic imperative, NCHHSTP defines "integration" as an opportunity that results in integrated services for clients regardless of the agency structure.

NCHHSTP conducted several activities in 2006 to support this strategic imperative. Internal workgroups were formed. The NCHHSTP Director made site visits to explore opportunities for program integration. A new initiative was developed to cross-train project officers and program consultants. New information technology tools were designed to facilitate cross-collaborations within NCHHSTP. Efforts are underway to recruit and fill a new position for the NCHHSTP Associate Director for Program Integration.

For "health disparities," NCHHSTP will attempt to improve the health of populations disproportionately affected by HIV, STDs, TB and other related diseases or conditions to advance toward eliminating health disparities. Target populations for this strategic imperative will include racial/ethnic minority groups, women, incarcerated persons, and

other communities and persons disproportionately affected by infectious diseases.

Several NCHHSTP divisions conducted activities in 2006 to support this strategic imperative. The Division of Tuberculosis Elimination convened a consultation in May 2006 and launched the "Stop TB in the African American Community" web site. The Division of STD Prevention (DSTDP) revised and released the "National Plan to Eliminate Syphilis in the United States." The Division of HIV/AIDS Prevention (DHAP) held a series of consultations and is now developing comprehensive plans to enhance HIV prevention among African Americans (AAs). The need to incorporate STD, TB and viral hepatitis prevention strategies for AAs was emphasized during the consultations.

CDC and its partners will sponsor the 2007 National HIV Prevention Conference on December 2-5, 2007 in Atlanta, Georgia. The conference is being designed to ensure that the needs of an evolving HIV prevention climate in the United States are met. Several CHAC members attended a planning meeting in October 2006 to provide advice on the agenda, speakers, abstracts, topics and other aspects of the conference. Similar to previous conferences, CDC expects CHAC to be strongly represented at the 2007 National HIV Prevention Conference.

Several personnel changes occurred in NCHHSTP's senior leadership after the previous CHAC meeting. Staff were appointed to serve in acting positions for the NCHHSTP Deputy Director, Associate Director for Health Disparities, Associate Director for Science, and Associate Director for Laboratory Sciences. NCHHSTP management will make every effort to fill the acting positions with permanent staff in 2007.

CHAC supported CDC's revised HIV testing recommendations that call for routine testing. However, several members expressed concerns with some aspects of the guidelines and made suggestions for CDC to consider in addressing these issues.

- CDC's revised HIV testing recommendations conflict with its 2001 HIV C&T guidelines and language in cooperative agreements. For example, the revised HIV testing guidelines advise grantees to collect an enormous amount of data and enter this information into the Program Evaluation and Monitoring System (PEMS). However, these actions cannot be taken with routine testing because information must be gathered directly from patients and informed consent must be obtained to provide HIV counseling. This approach would result in a two-tiered system in each state if CDC's revised HIV testing recommendations, 2001 HIV C&T guidelines, language in cooperative agreements, and PEMS data requirements are not changed to be consistent. CDC should resolve this dilemma as efforts are made to implement the revised HIV testing recommendations.

- CDC should develop HIV testing algorithms for private laboratories.

- CDC should create and disseminate printed information on HIV testing and the

rationale for including the test in the regular battery of tests.

- CDC's revised HIV testing recommendations do not acknowledge that existing laws requiring confirmatory tests are a major barrier to streamlining routinized testing. These laws also undermine linkages to care for emergency room patients and hard-to-reach populations. Most notably, one week is still required to obtain results of confirmatory HIV tests.
- CDC's revised HIV testing recommendations do not consider rapid confirmatory tests that are used in other countries. The antiquated approach of post-test counseling in the United States requires patients to present again to providers at a later time to obtain test results. This strategy results in missed opportunities to reach at-risk patients and address behaviors to reduce transmission of HIV.
- CDC should make plans at this time to ensure that persons who are newly diagnosed with HIV as a result of the revised HIV testing guidelines are linked to care.
- CDC's revised HIV testing recommendations do not federally recognize Native Hawaiians or provide a voice for this population.
- CDC's revised HIV testing recommendations do not acknowledge that health departments serve as a major barrier to grantees providing services to the "new faces" of HIV, such as women in Alaska and Alaska Native women.
- CDC's revised HIV testing recommendations do not include interventions and strategies specifically for small and rural areas.

Dr. Fenton and other CDC representatives provided additional details on CDC's activities in response to CHAC's specific questions, comments and concerns.

- CDC's revised HIV testing recommendations are designed to provide greater opportunities for HIV testing of at-risk populations in healthcare settings. CDC will publish updated guidelines for HIV testing in community settings in 2007 to assist CBOs in streamlining and modernizing HIV testing activities.
- CDC will expand existing models and best practices in the field throughout the country to implement the revised HIV testing guidelines. For example, the CDC Division of HIV/AIDS Prevention convened a meeting in October 2006 with various federal, provider and medical partners to obtain input on implementing the revised HIV testing guidelines in terms of funding allocations, expansion of existing best practices and models, and provision of capacity-building and training. Feedback from the partners will be captured in CDC's implementation guidelines for the revised HIV testing recommendations that will be released in 2007.
- CDC's revised HIV testing recommendations contain extremely clear guidance for providers to obtain consent from and accurately diagnose patients. For example, providers are advised not to administer HIV testing without the knowledge and full consent of the patient and to only give results of the test to the patient. Local

jurisdictions are also advised to identify and resolve legal barriers to HIV testing. Providers who do not comply with CDC's guidance on diagnosis and confidentiality would be at a greater risk to be sued by patients.

- CDC's revised HIV testing recommendations clearly identify and define "high-risk" populations, settings and behaviors for annual routine HIV testing, such as persons who present to STD clinics and drug treatment settings or individuals who report >2 sexual partners in the past year.
- CDC's Infertility Prevention Program is a top priority in DSTDP in terms of resources and need. The national reported rate of chlamydia is nearly 1 million cases. Reported cases of gonorrhea increased over the past year for the first time since the late 1990s. Both of these infections have enormous disparities. The prevalence of chlamydia and gonorrhea in family planning clinics and other sentinel settings has either flattened or slightly increased. CDC is aware that stronger actions need to be taken for chlamydia and gonorrhea, particularly screening in non-public sectors and wider screening and coverage of the currently recommended population of sexually active women <26 years of age.
- CDC will review and update its existing HIV C&T guidance to resolve any conflicts with the revised HIV testing recommendations.
- CDC will closely collaborate with partners to link persons who are newly diagnosed with HIV as a result of the revised HIV testing recommendations to care. The recommendations strongly emphasize, cite solid articles and describe CDC's demonstration projects on the importance of linkages to care. CDC will use newly-diagnosed HIV-positive persons as a mechanism to advocate for more HIV prevention funding.
- CDC will hold a meeting on the following day with PEMS stakeholders in an effort to reach agreement on a C&T data collection form. CDC and the stakeholders will also explore the possibility of developing a shorter form for STD clinics for opt-out purposes. A third form will be considered as well for settings not funded by CDC to collect minimal data on testing.
- CDC has prioritized and is currently taking actions to develop new HIV testing algorithms in 2007. CDC is aware that current tests are outdated and do not reflect the range of new HIV tests on the market.
- CDC will review, consider and expand excellent models of practice for inclusion in implementation guides of the revised HIV testing guidelines. The guidance on practice will cover the development of consent and testing forms, appropriate materials to display in waiting rooms, information to personally give to patients, and pre-test information in languages that would be understandable to persons undergoing routine HIV testing.
- CDC expects to partner with a professional organization to analyze existing laws and develop model language for confirmatory tests to facilitate streamlining of HIV testing.

- CDC will review its STD Treatment Guidelines to ensure that this guidance does not conflict with previous recommendations on STD treatment.
- CDC's domestic recommendations on HIV testing in the United States has no influence on the overall PEPFAR initiative. However, CDC's guidance might play a role in routine HIV testing administered by individual global partners.

Dr. McGuire noted that CHAC's discussions on CDC's activities are typically dominated by HIV/AIDS. As a result, she thanked Dr. Fenton for including CDC's viral hepatitis and STD activities in his comprehensive update. She conveyed that this information would assist CHAC in providing guidance on both HIV and STD prevention and treatment.

Similar to Mr. Milan's request during the HRSA session, Dr. McGuire also asked CHAC to make suggestions on CDC's activities that should be considered as potential formal motions for submission to the CDC Director or HHS Secretary. She listed four issues for CHAC to consider in this effort:

- The catalogue price of the HPV vaccine of $120/dose versus CDC's proposed contract price of $96/dose.
- The Adult HBV Initiative, such as the actual value of catch-up vaccination for all children and adolescents <19 years of age; integration of hepatitis A into the Adult HBV Initiative; and minimal savings from the federal 317 program for states and local jurisdictions to purchase HBV vaccine.
- CDC's efforts to integrate its HIV/AIDS, viral hepatitis, STD and TB prevention programs, particularly the need for more solid accountability, transparency and communications.
- The need for CDC to develop a strategic and time-sensitive approach to monitor the extensive amount of effort and resources that will be devoted to implementing the revised HIV testing recommendations. The need for CDC to create an effective process to address false-positive test results and other potential consequences of the revised HIV testing recommendations.

Update on the CDC National HIV Prevention Strategic Plan

Dr. McGuire concluded the session by confirming that CHAC would continue to discuss CDC's revised HIV testing recommendations to further address concerns raised by the members.

Dr. George Roberts, Associate Director for Prevention Partnerships in NCHHSTP and co-chair of the CHAC Strategic Plan Workgroup, covered the following areas in his report. From May 2005-May 2006, CHAC approved the establishment of the workgroup to review performance of the 2001-2005 Strategic Plan and make recommendations for updating the Strategic Plan during a three-year extension. The workgroup was formed with two co-chairs and 30 members. The workgroup convened two face-to-face meetings and presented its report to CHAC during the previous meeting.

The workgroup established several objectives to fulfill its charge. Priority goals, objectives and broad strategies of the Strategic Plan would be reexamined. Progress to date in reaching the goals and objectives would be discussed. Reasons for the nation not achieving some of the goals would be discussed. Gaps and necessary revisions in the goals and objectives would be identified. Recommendations would be made for prioritizing objectives under each goal. Strategies would be recommended to revise the Strategic Plan to achieve greater progress and success.

Numerous activities were conducted from July 2005-May 2006 for the workgroup to achieve the objectives. Background materials were reviewed, such as relevant articles by CDC and external researchers, related plans, guidelines and technical information. Presentations were made on several issues, including CDC's funding and activities for each goal, racial disparities, biomedical interventions and prevention effectiveness.

Strategies to increase the likelihood of reducing HIV transmission by 50% were presented to the workgroup from community, health department, care and policy perspectives. Progress and barriers to reaching goals and objectives were reviewed. Recommendations were made on updating the goals and objectives.

The workgroup identified a number of barriers to achieving the goals and objectives. The Strategic Plan was not accompanied by a social marketing campaign to increase public awareness and engage stakeholders. Endorsement of the Strategic Plan at national and community levels was lacking and led to minimal coordination and collaboration. The scope and relevance of the Strategic Plan to other federal agencies were not well defined.

The Strategic Plan did not delineate macro-level and structural factors that influence HIV transmission. Resources were inadequate. Targeting of the Strategic Plan to MSM and communities of color was ineffective. Effective preventive interventions were lacking for communities of color, particularly AAs and MSM. HIV prevention, C&T and

care systems were disconnected.

Several common themes emerged from the workgroup's discussions on updating the Strategic Plan. An overarching racial/ethnic disparities goal should inform implementation of objectives and strategies for all goals. A clear distinction should be made between goals and objectives related to PLWH and seronegative persons at risk of HIV infection. Goals and objectives related to care should be better specified, particularly for maintaining persons in care. Stronger language should be developed to emphasize the need for routine and available HIV testing in multiple settings, including non-healthcare facilities.

Interventions should be targeted to structural and social norms that lead to risk. Biomedical strategies should accompany behavioral interventions. Interventions should be targeted to persons with acute HIV infection as a strategy to interrupt transmission during highly infectious periods. Targeting for populations at highest risk of acquiring and transmitting HIV should be improved and based on incidence rather than prevalence.

The workgroup's major recommendations are highlighted as follows. To maintain the overarching numeric goal for reducing new infections, AAs should be prioritized at the highest level, within the overarching goal, and within each individual goal. MSM should be prioritized within the goals as appropriate. Racial/ethnic minority populations with a disproportionate burden of disease or incidence should be prioritized.

Under goal 1, separate prevention goals should be created for PLWH and seronegative persons at risk of infection. Goals on testing and linkage to care should be updated. A new goal should be added to address stigma and discrimination. Goal 4 on surveillance and capacity-building should be eliminated because strategies and objectives for these issues should be included in all goals.

The workgroup proposed five specific goals for the updated Strategic Plan:

- Goal 1: By 2008, decrease by at least Y% the number of PLWH at risk of transmitting HIV.
- Goal 2: By 2008, decrease by a least Y% the number of persons at risk of acquiring HIV.
- Goal 3: Increase the percentage (from X% to Y%) of persons [of HIV-positive persons] in the United States who know their HIV infection status through routine testing in diverse settings.
- Goal 4: By 2008, increase from the current estimated ??% to ??%, the proportion of persons with HIV who are receiving appropriate prevention, care and treatment services.
- Goal 5: Increase public awareness of HIV and reduce HIV-related stigma and discrimination.

The workgroup recommended several issues that should be considered in updating all goals and objectives across the Strategic Plan.

- Improve all goals and objectives to achieve better targeting. For example, testing efforts should be differentially targeted by prevalence and incidence. The efficacy of improving interventions with the most infectious persons should be determined. Specificity should be increased for populations and settings where linkages to care would occur.
- Develop and use improved models to differentially assess efficacious and cost-effective interventions and describe an optimal mix of interventions. Include an expanded focus on system and structural interventions and necessary mobilization in this framework.
- Analyze resources at the objective level to allow goal targets and funding allocations to be adjusted and monitored over time.
- Develop a strategy regarding expanded resources for care.
- Develop a mechanism to appropriately align evaluation and capacity-building activities and resources in prior goal 4 across the new goals and objectives.
- Establish resources, necessary federal and other partners, and other scale-up models.
- Acknowledge that success of the updated Strategic Plan will depend on taking different approaches, clearly defining a road map, and implementing a detailed mobilization strategy.
- Monitor and annually report on progress of the goals.

To guide the discussion, Dr. McGuire and Mr. Milan informed CHAC that CDC needs specific guidance to take next steps on the updated Strategic Plan. For example, CHAC should consider whether the originally proposed three-year extension should be expanded for an additional two years for a five-year updated Strategic Plan. CHAC should identify solid strategies for CDC to allocate HIV prevention resources. CDC should not be placed in a position of attempting to achieve the updated Strategic Plan goals in the current environment of inadequate resources.

CHAC applauded CDC's efforts to support the workgroup's charge of updating the Strategic Plan. Most notably, CDC provided data and a wealth of expertise to assist the workgroup in making recommendations. Several CHAC members made suggestions for CDC to consider in finalizing the updated Strategic Plan.

- A strong disclaimer should be included in the Strategic Plan to emphasize that the goals cannot be achieved without adequate resources. The language should also note that insufficient funding was the major cause of the failure to reach the previous Strategic Plan goal of reducing HIV transmission by 50%.

- CDC should leverage resources with federal partners and other sectors over time to develop a National Plan for HIV Prevention, Treatment and Care.
- CDC should take advantage of existing opportunities to pilot HIV prevention initiatives in collaboration with federal partners. For example, 5% of Substance Abuse and Mental Health Service Administration (SAMHSA) block grants is set aside for HIV/AIDS in key states, but this option should be expanded and available to all states. The 5% set-aside in SAMHSA block grants is not restricted in terms of pre-/post-test counseling and wraparound services. Due to current and future budget cuts, communities must be able to take advantage of HIV/AIDS dollars from sources other than CDC.
- The Strategic Plan should not be extended for an additional two years at this time due to current uncertainties, such as the upcoming implementation of CDC's revised HIV testing recommendations, existing flaws in PEMS and severe budget constraints.
- CDC should sponsor another workgroup meeting to identify and discuss other priority populations for HIV prevention, such as AA heterosexual men, AA women, youth, Hispanics and Alaska Natives. Prioritization of MSM and AAs in the Strategic Plan could be misinterpreted to mean that HIV is only a problem in these two populations.
- CDC should develop accountable, realistic, reasonable, attainable and measurable indicators to monitor progress of the Strategic Plan.

Dr. Robert Janssen, Director of DHAP, clarified that DHAP has not yet formally responded to the workgroup's recommendations on the updated Strategic Plan because internal discussions are still underway. However, he described several actions DHAP is considering to finalize the updated Strategic Plan.

DHAP intends to target resources to HIV testing of AAs and MSM if funds are allocated in the FY'07 appropriation for the President's rapid HIV testing initiative. DHAP is currently obtaining input from external partners on its heightened response to the HIV epidemic in the AA community. DHAP expects to release a concrete plan from this effort in early 2007. The guidance will reflect feedback DHAP gathered from its previous consultations and other activities to address the HIV epidemic in the AA community. DHAP will develop new strategies and use existing methods to sustain previous mobilization efforts in the AA community.

DHAP's senior leadership will convene a budget and strategic planning retreat on November 28, 2006 that will include a review of all Strategic Plan objectives and identification of the top ten priorities across all goals. In preparation of the retreat, DHAP developed and added new objectives to the Strategic Plan goals that are consistent with the workgroup's recommendations.

DHAP is collaborating with and obtaining input from both internal and external partners to develop a model for allocating resources and analyzing the impact of the HIV

epidemic. DHAP expects to review results of the model in January or February 2007. The data will assist DHAP in determining whether existing HIV prevention interventions are appropriate or if new models should be developed focusing on cost-effectiveness, the efficacy of interventions and the impact of the HIV epidemic.

DHAP incorporated stigma into each objective to address the workgroup's new goal on this issue. CDC's revised HIV testing guidelines also address stigma by recommending universal screening instead of testing on the basis of risk factors.

DHAP will develop performance indicators to monitor progress on the Strategic Plan. DHAP expects to create annual targets for national HIV incidence and will develop other annual measures after CDC's existing monitoring systems are refined.

Dr. Janssen concluded his comments by expressing strong support of the workgroup's proposed recommendation for an additional two-year extension for a five-year updated Strategic Plan.

Panel Presentations on Issues Impacting the Strategic Plan

Ms. Jennifer Kates, Vice President and Director of HIV Policy at the Kaiser Family Foundation and a Strategic Plan Workgroup member, described issues that would affect the Strategic Plan. Of the total FY'06 federal budget of $2.6 trillion, $21.1 billion or <1% was devoted to HIV/AIDS prevention, care, treatment and research. Although this amount represented a small percentage of the total FY'06 federal budget, federal funding for HIV/ AIDS dramatically increased from $0 in 1981 to $22.8 billion in the President's FY'07 budget request.

In FY'06, 55% of the federal HIV/AIDS budget was mandatory as a result of Medicaid, Medicare, Supplemental Security Income, Social Security Death Index, and Federal Employees Health Benefits programs. The remaining 45% of the federal HIV/AIDS budget was discretionary as a result of annual Congressional appropriations for the CARE Act and HIV/AIDS research, global, housing and prevention programs. Discretionary funding decreased from 1981-2006 because more persons are now living with HIV and are eligible for mandatory care and income assistance programs. For example, 50% of federal funding for HIV/AIDS was allocated to research in FY'82, while 58% was allocated to care and treatment and only 4% was allocated to prevention in FY'06.

Federal agencies are the primary recipients of domestic HIV prevention funding with the majority of these dollars allocated to CDC. Of $869 million in federal funding for domestic HIV prevention in FY'06, CDC received $719 million or 83%. CDC distributes these funds to states, cities, CBOs and other programs. Other recipients of HIV

prevention funds include other federal agencies, state and local governments and private-sector groups.

CDC's federal funding for domestic HIV prevention increased from $0 in FY'82 to $719 million in FY'06 based on nominal dollars. However, the FY'06 amount is nearly the same as FY'92 dollars based on inflation. The President's budget requests for domestic HIV prevention increased from $872 million in FY'05 to $956 million in FY'07. Of the President's FY'07 budget request of $956 million for domestic HIV prevention, $808 million or 85% would be allocated to CDC, including a $93 million proposed increase.

In FY'05, CDC/DHAP distributed $374.6 million or 59% of its total $633.8 million budget to state and local health departments. DHAP allocated the remainder of the budget to capacity-building, intramural programs, directly funded CBOs, research, program evaluation and interagency agreements. DHAP's HIV prevention funds to the top ten states in FY'05 ranged from ~$77.3 million to New York to ~$15.8 million to Massachusetts.

CDC's HIV prevention budget is an important factor that CHAC must consider in providing guidance on the updated Strategic Plan. For example, CDC's revised HIV testing guidelines for routine screening are targeted to persons 13-64 years of age. According to the most recent U.S. Census estimates, ~200 million persons account for this population in the United States. Of this population, ~1.2 million are HIV-positive. Of this population, ~250,000 are HIV-positive and do not know their status. CDC's resources are targeted to reaching this population, informing these persons of their status, and making linkages to care.

Of ~1.2 million HIV-positive persons in the United States, 25% are undiagnosed, 25% are diagnosed and not in care, and 50% are in care. PLWHA had the following insurance coverage based on 1996 data: 31% with private insurance, 29% with Medicaid, 13% with Medicaid/Medicare, 6% with Medicare, and 20% uninsured. More recent data collected in 2002 from 17 HIV clinics throughout the country showed a change in insurance coverage of PLWHA: 34% with Medicaid, 16% with private insurance, 13% with Medicaid, 4% with Medicaid/Medicare, and 28% uninsured.

Data collected from 25 states from 1994-2000 showed that private insurance accounted for 33% of PLWHA at the time of diagnosis, Medicaid accounted for 22%, other public or government programs accounted for 19%, and no insurance accounted for 27%. Data collected in 2004 from 35 areas showed that 61% of AIDS diagnoses were made >12 months after HIV diagnoses.

Data collected in 2002 on HIV testing by facility and diagnosis showed that hospitals, emergency rooms and community clinics diagnosed most HIV-positive patients. Data collected in 2003 on PLWHA by awareness of serostatus showed that undiagnosed persons were more likely to be AA and Hispanic based on race/ethnicity and MSM and heterosexual based on transmission.

Ms. Kates summarized key points for CHAC to consider in providing further guidance to CDC on implementation of the updated Strategic Plan. The Strategic Plan and revised HIV testing recommendations target two populations: all persons 13-64 years of age for routine screening and a subset or <1% of the population that is estimated to be HIV-positive and undiagnosed. The undiagnosed population is more likely to be uninsured persons of color, rely on public assistance, infected through sexual contact, and present to emergency rooms and community clinics.

Linkages to the care system will be critical in implementing the updated Strategic Plan and revised HIV testing recommendations because ~50% of diagnosed persons have no access to care and 39% are diagnosed late. ADAP waiting lists; other barriers to the care system; and resources from federal, state and local systems will need to be addressed to implement the Strategic Plan.

Dr. David Holtgrave, of Johns Hopkins Bloomberg School of Public Health, provided additional data on issues that will affect the Strategic Plan. Since the mid-1980s, successful HIV prevention programs have led to a decrease in the number of new infections in the United States from 160,000/year to ~40,000/year. The investment in HIV prevention also resulted in societal cost-savings. Modeling has been performed to estimate the number of new infections that would have occurred each year without HIV prevention programs. The scenarios projected that ~1.5 million infections were prevented in the United States from 1985-2000.

The rate of HIV transmission from PLWH to seronegative partners dramatically decreased from ~100% in the early stage of the epidemic to 4% in 1990. These data showed that at least 96% of PLWH were not transmitting HIV in a given year. HIV transmission rates are estimated to be 8.8%-10.8% in persons who are unaware of their HIV seropositivity and 1.7%-2.4% in persons who are aware of their HIV seropositivity. C&T play a major role in the significant differences in HIV transmission rates between the two groups. A paper that is in press showed a strong relationship between resources and HIV incidence after 1985.

The overarching national goal in the 2001 Strategic Plan was to reduce the number of new HIV infections in the United States from an estimated 40,000 to 20,000 per year by 2005 with a particular focus on eliminating racial/ethnic disparities in new HIV infections. The November 18, 2005 edition of the MMWR contained an article on HIV/AIDS diagnoses collected from 33 states with name-based reporting systems from 2001-2004. Over the four-year period, 157,252 diagnoses were made in the 33 states. These data suggested that HIV incidence in the United States was well over 40,000/year in the United States in 2005.

Sub-goal 1 in the 2001 Strategic Plan was by 2005, to decrease by at least 50% the number of persons in the United States at high risk for acquiring or transmitting HIV infection by delivering targeted, sustained and evidence-based HIV prevention interventions. Progress on this goal is uncertain due to unclear language and the lack of national sexual behavior data. However, a published study showed that HIV-positive

persons reduced risk behaviors by 68% after learning of their HIV seropositive. Other data showed that ~11.7%-11.9% of the general U.S. population were at heightened risk of HIV due to sexual transmission, drug use risk behaviors or a current STD.

Sub-goal 2 in the 2001 Strategic Plan was by 2005, to increase from the current estimated 70% to 95% the proportion of HIV-infected persons in the United States who know they are infected through voluntary C&T. The lack of progress on this goal was demonstrated by CDC's estimate of a 73%-76% awareness level of HIV in 2005.

Sub-goal 3 in the 2001 Strategic Plan was by 2005, to increase from the current estimated 50% to 80% the proportion of HIV-infected persons in the United States who are linked to appropriate care and treatment services. The lack of progress on this goal was demonstrated by a 2004 Institute of Medicine report that estimated only 49.7% of persons in need of highly-active ART actually received therapy.

For the updated Strategic Plan, the national goal should be maintained to reduce new HIV infections in the United States to 20,000/year or less by 2010 and place particular emphasis on racial/ethnic health disparities. However, the goal should be expanded to monitor progress with annual report cards on the national investment; develop process measures for policy implementation, reduce barriers and service delivery; and assess annual outcomes. The goal will continue to be important because 5-26.3 million persons are seronegative, but have behavioral risks for HIV infection. CDC has estimated that ~1.1 million PLWH are in the United States. Of this population, ~25% are unaware of their status.

A meta-analysis showed that after PLWH obtain C&T, ~16% will still continue to engage in risk behaviors. Based on these data, several sub-goals should be considered for the updated Strategic Plan. Risk behaviors should be decreased and serostatus awareness should be promoted. Care and treatment should be available to all persons who need these services.

Information should be more widely disseminated to the general public to combat stigma of HIV. CDC should partner with the National Institutes of Health (NIH) to invest in and conduct research on new interventions to decrease stigma. Serostatus-specific HIV prevention efforts should be targeted to HIV-positive persons; recently tested HIV-negative persons who are at continued behavioral risk of infection; persons who are unaware of their HIV status; and the general population.

A paper that is in press analyzed the potential impact of HIV seropositivity awareness on HIV incidence via C&T. The data showed that prevented HIV infections could be achieved by lowering the transmission rate from 9% to 2%. An analysis that is currently under review for publication examined the costs and consequences of four HIV testing scenarios. The analysis showed that if HIV screening rates were increased to 52% in the target population, ~65 million persons would need to be tested and ~56,000 seropositive persons would be reached. Total program costs of this effort were

estimated at ~$864 million. The gross cost per avoided infection was estimated at $237,149. To provide care and treatment for newly-diagnosed persons, ~$961.3 million would need to be set aside in the first year. Overall, the analysis demonstrated that ~$1 billion would be needed to support a new Strategic Plan.

Dr. Holtgrave summarized several issues for CHAC to consider in providing additional guidance to CDC on implementing the Strategic Plan. C&T and serostatus awareness are important interventions, but are not sufficient to achieve an "HIV disease elimination" program. As a result, HIV prevention interventions should be designed to include individual, dyad, family, group, community and structural levels, such as laws, policies, environments and social determinants. HIV prevention interventions should also focus on sexual, perinatal and parenteral transmission, including interventions for small groups, communities and housing. Structural interventions should be designed to strengthen social capital at the community level to impact STDs, AIDS and teen pregnancies.

HIV prevention programs have changed the course of the epidemic in the United States, but additional progress must be made to further reduce the number of new infections. Previous efforts should be scaled-up to conduct activities in the future and allocate resources for these initiatives. HIV prevention programs have decreased incidence, but flat funding of these activities must be addressed. Targeted HIV C&T might have substantially more public health benefits than opt-out testing at the same cost.

Additional promotion of serostatus awareness via C&T might decrease the national annual incidence of 40,000 new HIV infections to 25,000-30,000 for a true HIV disease elimination program in the United States. However, serostatus awareness will play a minimal role in further reductions in incidence. A multi-component, multi-level and comprehensive National Plan for HIV Prevention, Treatment and Care for the United States is urgently needed as soon as possible. The new national plan should be supported by substantial resources to provide high-quality HIV care and treatment to persons newly diagnosed with HIV through C&T campaigns.

To guide the discussion, Dr. McGuire and Mr. Milan emphasized the importance of CHAC providing guidance on models and resources for implementation of the updated Strategic Plan and the need to develop a new National Plan for HIV Prevention, Treatment and Care.

Several CHAC members suggested additional issues that should be considered in implementing the updated Strategic Plan.

- A new strategy should be developed to collect surveillance data on diseases to ensure these variables are clearly defined.
- Data from the HIV prevention economic models should be re-analyzed to determine cost-savings from HIV-positive persons who were diagnosed, received care and engaged in safer practices.

- The intersection between violence and HIV should be included in structural interventions.
- CDC should attempt to allocate resources and take other actions at this time to advance toward an HIV disease elimination program.
- Quantifiable goals should be incorporated into the updated Strategic Plan to assist in obtaining a justified budget that is based on the science and actual numbers of HIV-positive persons.
- CHAC should make strong recommendations for increased funding to reduce the number of new HIV cases. For example, language could be included in the updated Strategic Plan or a companion document to emphasize that new resources will be needed to implement the prioritized interventions and other innovative strategies to further decrease the number of new HIV infections per year.
- The Strategic Plan should outline approaches to address new barriers to providing HIV prevention, education treatment and care in the future. For example, the change in the CARE Act legislation for HIV-positive persons to be identified through name-based reporting systems in 2007 might undermine these efforts.

Public Comment Period

Mr. Carl Schmid, of The AIDS Institute (TAI), made comments on two topics CHAC discussed during the meeting. First, TAI acknowledges the importance of implementing a reauthorized CARE Act in 2007. A delay in implementing the new law in 2008 would create major funding disruptions in several states and local jurisdictions. HIV case counts must be included in 2007 according to the legislation and some states do not have HIV case counts that have been accepted by CDC.

Second, TAI strongly supports CDC's revised HIV testing recommendations that call for routine voluntary HIV testing in healthcare settings, but certain aspects of the guidelines should be addressed. The broader HIV/AIDS community should be included in CDC's implementation plans for the revised HIV testing recommendations. Written information on HIV should be developed and disseminated because the guidance does not require prevention counseling through informed consent. Other components that would be included in consent and post-test counseling processes should be widely communicated to constituents.

TAI is pleased that CDC's revised HIV testing recommendations reflect its previous suggestions on opt-out testing, the provision of basic HIV information, and the distribution of materials in multiple languages. TAI is interested in learning about the implementation plans for the revised HIV testing recommendations and looks forward to collaborating with CDC in this effort.

Ms. Thelma King Thiel, of Hepatitis Foundation International (HFI), urged CDC and HRSA to target prevention, care and treatment efforts to persons <16 years of age. The Strategic Plan should describe primary prevention and educational interventions to encourage young persons to adopt healthy lifestyle behaviors and strongly recommend implementation of these efforts in schools. HFI's previous and ongoing training sessions, evaluations and other joint projects with diverse groups at federal, state, local and private levels have shown that hepatitis testing would save healthcare dollars.

Ms. King Thiel particularly thanked CDC for assisting HFI in developing and widely distributing school-based products. She confirmed that HFI would continue to collaborate with CDC, SAMHSA, schools and other organizations to widely promote primary prevention among youth.

Dr. Marsha Martin, of the Washington, DC Administration for HIV Policy and Programs (AHPP), informed CHAC that the majority of HIV testing occurs in privately-financed medical settings. However, no efforts are being made in the private sector to assist grantees in collecting data to manage HIV screening and coordinate care.

The HIV epidemic cannot be appropriately managed unless both public and private systems are included in a coordinated effort for purposes of data, care and other components. For example, AHPP has no data on persons who are screened by healthcare maintenance organizations, student health centers and other private healthcare settings because CDC only requires reports of HIV-positive results from private facilities.

Dr. Martin urged CDC and HRSA to make stronger efforts to assist grantees in integrating data from both public and private sources. She provided CHAC with background materials on AHPP's campaign that was launched to routinize HIV screening.

With no further discussion or business brought before CHAC, Mr. Milan recessed the meeting at 4:40 p.m. on November 2006.

Panel Presentations on National HIV and STD Strategies for Youth

Dr. McGuire reconvened the CHAC meeting at 8:32 a.m. on November 14, 2006 and yielded the floor to the first presenter.

Dr. Howell Wechsler, Director of the CDC Division of Adolescent and School Health (DASH), provided an update on CDC's adolescent sexual and reproductive health activities. Of all high school students in the United States, 47% are sexually experienced. Persons 15-24 years of age account for nearly 50% or 9.1 million of all

new STDs acquired each year. Based on data from 33 states with confidential name-based HIV infection reporting systems, an estimated 4,824 HIV cases occur annually among persons 15-24 years of age. Persons 15-19 years of age account for 831,000 of all pregnancies that occur each year.

Recent trends in STD, HIV and teen pregnancies are summarized as follows. Since the early 1990s, the percent of sexually active youth has decreased and the use of condoms and contraception has increased among sexually active youth. Improved screening has led to increased rates of some STDs. Pregnancy rates have decreased overall, but smaller reductions were seen in ethnic/minority youth. Most recent data suggest that rates are not continuing to decrease and have remained level in most states.

Racial/ethnic populations are disproportionately affected by these trends. The rate of sexual intercourse is 68% among AA high school students compared to 51% among Hispanics and 43% among whites. AA adolescents represent 70% of all HIV/AIDS cases among persons 13-19 years of age. Data from 2004 showed that Hispanics accounted for ~83% of teen births compared to 61% among AAs and ~27% among whites. The 47% decline in teen birth rates among AAs was the largest compared to whites and Hispanics.

CDC recently published a paper on the percentage of high school students who ever had sexual intercourse by race/ethnicity from 1991-2005. The data showed a dramatic reduction in AA students who had sexual intercourse through the 1990s, but the decrease has stopped since 2001. The slight reduction in sexual intercourse among Hispanic adolescents was not statistically significant.

DASH, DHAP, DSTDP and the CDC Division of Reproductive Health formed an internal Workgroup on Adolescent Sexual and Reproductive Health (WASRH) which developed a report on CDC activities in this area. The four divisions allocated a total of $77.3 million to conduct 192 different youth projects in three categories: (1) research on adolescent sexual and reproductive health; (2) direct services for HIV, STD and pregnancy prevention; and (3) training, technical assistance and capacity-building programs for adolescent sexual and reproductive health.

For the research category, the four divisions have conducted studies on sexual risk behaviors, pregnancy, STDs and HIV. The projects were designed as observational, surveillance, intervention or primary prevention studies in various units and settings, such as individual, group, family or community units and clinic, community, school or juvenile justice settings. A three-phased activity was conducted to identify, package and disseminate evidence-based interventions. Collaborations were established with national organizations and state teen pregnancy coalitions to assist local groups in selecting, adapting and implementing science-based programs.

For the direct services category, the four divisions provided STD screening and

treatment, HIV C&T, training for peer-based education and support, social marketing campaigns, prevention education, behavioral interventions, infrastructure development, surveillance and program evaluation. Funding was awarded to ten CBOs to offer prevention programs to young MSM of color.

Of the populations served across sites, ~50%-80% were <21 years of age. At least 10% of youth were included in 35 state and local health departments that were funded to provide program services. Seven CDC programs targeted or provided services to HIV-infected youth or youth at high risk for HIV, such as MSM, female sex workers, homeless youth and youth in juvenile justice systems. CDC supported comprehensive STD prevention systems through its Infertility Prevention Program, 50 state health departments and seven local health departments.

For the capacity-building assistance category, the four divisions provided information, technical assistance, training and technology for persons and organizations to improve service delivery and effectiveness. These services were targeted to education agencies at state, territorial and local levels, national NGOs, state teen pregnancy coalitions, Title X regional training centers and CBOs. The capacity-building activities were designed for utilization of science-based approaches to promote adolescent reproductive health, consumer outreach, recruitment, training, leadership development and strategic planning.

Dr. Wechsler concluded his update by responding to CHAC's request during the previous meeting for more information on CDC's adolescent sexual and reproductive health activities. The Health Education Curriculum Analysis Tool (HECAT) was developed to provide evidence-based guidance to schools on selecting curricula that would most likely be effective in improving the health of young persons. HECAT has been undergoing the HHS clearance process for more than one year.

DASH provided input on a document that was developed by the Office of Population Affairs on a scientific process for abstinence-only grantees to plan abstinence programs with a more rigorous approach. This document has been undergoing the federal clearance process for 1.5 years. Two evidence-based interventions developed by DHAP are still undergoing the HHS clearance process.

Dr. Wechsler also pointed out that materials were distributed to CHAC. One handout described individual projects and funding amounts for 17 national non-governmental organizations that were awarded to support HIV prevention for youth over the next five years. Another handout described additional HIV projects conducted by other grantees. Overall, Dr. Wechsler was pleased that CDC's current activities are eliminating silos and barriers to streamlining services for young persons.

Dr. Jose Morales, of HRSA, described HRSA's services for adolescents living with HIV/ AIDS. HRSA is an access agency with programs that are designed to provide care to persons with HIV, ensure the quality of care, include secondary prevention and decrease transmission. Under Title IV of the CARE Act, HRSA implements 17 programs

specifically for youth living with HIV/AIDS and provides services to this population on the basis of gender, race/ethnicity and exposure. HRSA's total budget for the 17 youth programs is ~$4 million. Demographics of clients in Title IV programs are 2% transgender with an equal balance between males and males, 65% AA, 20% Hispanic, 34% with heterosexual contact, 26% MSM, and 24% perinatal.

HRSA's Title IV programs on sexual and reproductive health foadolescents are guided by the following strategies. Additional morbidity should be limited with annual gynecological tests and PAP smears for young female adolescents. Appropriate routine testing of STDs should be administered to young female adolescents. Mother-to-child transmission should be prevented with ART. Early prenatal care should be available to improve health. ART should be provided to neonates. HRSA's Title IV programs are required to link to Title X programs and include family planning services through either referrals or onsite pregnancy tests.

HRSA takes several actions to monitor the quality of care of Title IV programs for adolescents. Close communication and coordination are maintained with grantees through regular contact with project officers, compliance site visits and technical assistance. Under the National Quality Center, grantees can use the HIVQUAL method and other quality processes to focus on annual syphilis testing, Pap smears and other testing for other STDs. HRSA's focus on quality in 2007 will assist providers in improving efforts to obtain Pap tests.

HRSA established several criteria to determine the success of its Title IV programs for youth. Activities should be client-centered to meet the needs of clients from both developmental and geographical perspectives. Interventions should be designed to be client-driven, non-judgmental and caring. Services and systems should be integrated to serve different types of youth, including gay, lesbian, bisexual, transgender, heterosexual and street youth. Referrals should be incorporated into programs to decrease the loss of clients. Collaborative efforts should be undertaken with testing sites to reduce the time between discovery of HIV infection and entry into care.

Peers should be used for case finding, C&T and speaking to youth. Youth should be trained and employed for outreach, education and C&T. Youth should be educated to deliver education in schools and other community settings. Case finding should be performed in high-risk situations and should be consistent in reaching these areas. Multiple strategies should be implemented to reiterate consistent messages. The role of peers should be obvious and identifiable. Appropriate services should be offered to establish trust with potential clients.

HRSA is currently funding eight demonstration projects under the SPNS initiative targeting young MSM of color. The projects are focusing on outreach, care and prevention for young HIV-infected men 13-24 years of age. Three key objectives were established for the projects. Innovative outreach strategies would be supported to assist HIV-infected persons learn their status. HIV-infected persons would be linked

with primary care services that are appropriate for youth. Transmission of HIV infection would be prevented among target clients. The grantees are now completing the third year of the five-year funding cycle of the young MSM of color initiative and have established a web site with strategies, project summaries and other information to monitor progress and resources.

AETCs are using a variety of tools to educate providers on offering education, training and other services for adolescents living with HIV/AIDS. For example, the Pennsylvania/Mid-Atlantic AETC developed a series of reference tools on case finding, primary and secondary prevention for adolescents, clinical risk assessment and screening. HRSA will continue its close collaborations with CDC to ensure that project officers in the two agencies coordinate prevention, care and treatment efforts with the same grantee. The partnership has served as a valuable mechanism for HRSA and CDC project officers to communicate on a regular basis, share information and maximize resources.

Dr. Morales confirmed that HRSA will continue to develop innovative strategies to address challenges in its Title IV programs for adolescents. The most effective C&T models will be identified to find and retain infected youth in care. Assistance will be provided to transition youth to adult care systems to ensure continuity of care and other services.

Mr. Shepherd Smith, of The Institute for Youth Development, described strategies to incorporate public health principles into HIV/AIDS prevention for youth. The primary predictor of an individual acquiring HIV or another STD is the number of lifetime sexual partners. The age of sexual debut plays a significant role in the number of lifetime sexual partners. Two studies showed tremendous differences between adolescents with sexual debut at <14 years of age versus those with sexual debut at >17 years of age. The risk of acquiring an STD was 30-fold higher and the risk of having >6 sexual partners by 20 years of age was 7.5-fold higher with early sexual debut compared to delayed sexual debut. The results were similar between sexually active males and females.

A study showed that the median age at sexual debut was 14.5 years among HIV-positive females compared to 15.5 years among HIV-negative females. The median number of lifetime partners, acquisition of any STD and rates of unprotected vaginal sex were higher in HIV-positive females, but regular condom usage was the same between the two groups.

A study showed that forced or unwanted sex among female teens was higher at earlier ages. A study was conducted with students in grades 9-12 who reported having >4 sexual partners during their lifetime. The findings showed that this population is at highest risk, but have the lowest usage of condoms on a regular basis. By race/ethnicity and gender, young AA males were found to be at highest risk compared to Hispanics, whites and females.

Findings from all of these studies emphasize the need to better articulate the benefits of delayed sexual debut and a reduction in sexual partners. Activities targeted to youth do not clearly communicate the following messages: "more risk with more sexual partners;" "less risk with fewer sexual partners," and "virtually no risk with one lifetime uninfected partner." Youth programs also do not specifically target messages to young males about forced or unwanted sex with females.

Several factors have a positive influence on youth. Data show that parents, particularly those with high monitoring of their children, are the primary influence on delayed sexual debut. Youth who eat dinner with their parents >5 times per week are less likely to use alcohol, tobacco or marijuana compared to youth who infrequently eat dinner with parents 0-2 times per week. Shared family meals facilitate accountability, bonding and communication. Youth who develop refusal skills regarding sexual activity are less likely to attempt suicide or engage in other risky behaviors.

A study showed that youth were extremely challenged by achieving perfect use of contraception because the subjects chose intimacy rather than correct usage. In a study with males who were taught about condom use during college, 60% did not discuss condom use with partners before sex; 43% put condoms on after starting sex; 42% wanted to use condoms, but had none available; 40% did not leave space at the tip of the penis; 32% lost erections in association with condom use; 30% placed the condom on upside down; and 15% removed the condom before ending sex.

Mr. Smith pointed out that several conclusions can be reached based on data from the youth studies. One lifetime partner should be a universal goal and mentioned often in HIV prevention messages. Emphasis should be placed on limiting the number of partners. All youth should be encouraged to delay sexual debut. More attention and resources should be directed toward gay, AA and Hispanic youth. Specific programs should be developed to reduce the number of partners in these populations.

More education should be provided to parents about their responsibility to the sexual health of their children. More support should be offered to after-school programs. NCHHSTP should closely collaborate with DASH to develop more youth programs. For example, DASH has developed strong relationships with numerous youth-serving organizations, while NCHHSTP has the science base and expertise in HIV/AIDS and STDs. DASH's organizational network and NCHHSTP's knowledge should be combined to jointly provide HIV and STD education to adolescents.

Dr. David Wiley, Professor of Health Education at Texas State University, described several efforts schools can undertake to end the conspiracy of silence regarding HIV and STD prevention and treatment for youth. Data were collected and evaluated on the characteristics of effective curriculum-based programs. The focus on behavior should be specific and narrow, such as delaying sex or using condoms. Theoretical approaches with demonstrated efficacy in influencing other risky health-related behaviors should be replicated.

Clear messages should be communicated about sex and protection against STDs or pregnancy. Basic rather than detailed information should be provided. Peer pressure should be addressed. Communication skills should be taught. Interactive activities should be incorporated. The age, sexual experience and culture of young persons in the program should be reflected. Programs should last at least >14 hours. Leaders should be carefully selected and trained.

In terms of laws for sexuality and STD/HIV education in U.S. schools, the District of Columbia and 19 states require sexuality education, while 32 states do not have this requirement. The District of Columbia and 36 states require STD and HIV/AIDS education, while 15 states do not have this requirement. The content of these requirements varies among states, such as a full-fledged curriculum approved by the state, local rather than state control of the law, guest presenters speaking to a class, or distribution of materials to students. Title V grantees must adhere to eight federal mandates of an abstinence educational or motivational program.

Federal funding for abstinence-only sexuality education progressively increased over the years with Texas serving as the largest recipient in 2005. Texas has no approved curriculum for sexuality education, but a textbook was developed for this purpose. However, the textbook does not mention contraception and uses “scare tactics” about the possibility of being prosecuted for rape or sex with a minor.

Texas spends >$9 billion each year to address teen pregnancies and the consequences of unintended births. In 2004 alone, these costs included $165 million for public health care, $83 million for child welfare, $161 for incarceration of youth of teen mothers, and $349 million for lost tax revenues. Taxpayers in Texas spent $15.1 billion to support >745,000 teen births between 1991-2004.

Dr. Wiley encouraged all states to consider available options to improve HIV and STD prevention and treatment programs for youth. For example, existing state mandates should be reviewed to determine if federal funding can be more flexible to discuss all sexual options with youth.

The Florida, Kansas and South Carolina Departments of Education convene “Finding Common Ground Summits” with supplemental abstinence funding from CDC. Staff from abstinence-only, planned parenthood, comprehensive and family programs attend the summits in an effort to identify areas where agreement can be reached at the local level, such as sharing resources at health fairs and presenting packets of materials to school districts from all programs.

Cadre members are trained and team-building activities are conducted to develop more effective youth programs. Action planning summits are held six months later and activities are followed at the state level. The summits have been extremely successful in convening staff from various programs with diverse perspectives to communicate, collaborate and cooperate in HIV and STD prevention and treatment programs for youth. Efforts are underway to replicate the summits in more states.

HECAT provides evidence-based guidance to schools on designing, selecting and evaluating appropriate curricula for youth. However, HECAT is still undergoing the HHS clearance process and cannot be distributed to schools at this time. CHAC should make a strong recommendation to the HHS Secretary to expedite the clearance process for immediate dissemination of HECAT to schools.

A stronger focus should be placed on developing and distributing culturally-appropriate materials to underserved populations, particularly AA and Hispanic youth. School board members, administrators and teachers should be trained and informed about solid data that show linkages between student health outcomes and academic achievement. Assistance should be provided to schools on developing policies for HIV, human sexuality education and testing. Schools should be supported with advocacy and skills on managing controversies related to HIV and STD prevention and treatment programs for youth.

Several CHAC members made suggestions for CDC and HRSA to consider in refining national strategies to prevent and treat HIV and STD infection in youth.

- More emphasis should be placed on involuntary sexual debut through force, domestic violence or other types of abuse in the home. Appropriate messages on this issue should be developed and delivered beginning at the first-grade level.
- A clear distinction should be made between “functional” and “dysfunctional” families. For example, youth who eat dinner with their parents >5 times per week could be just as likely to engage in risky behaviors as those who share meals with their parents on a more infrequent basis.
- Stronger efforts should be made to engage the media in youth initiatives because the vast majority of advertisements and entertainment programs promote sex.
- Parents should be educated about the critical importance of serving as true role models. For example, adolescents will be less likely to follow parental advice if parents have multiple sex partners, give birth to children out of wedlock, and engage in the same risky behaviors as youth.
- HRSA should include pregnancy prevention and hepatitis B and HPV vaccination in its strategies to limit additional morbidity of STDs among youth.
- HRSA should reconsider its focus on annual syphilis testing because this infection has a larger impact on older adults than youth. Emphasis should be placed on the ongoing chlamydia epidemic because this infection primarily affects persons <20 years of age.
- Copies of articles should be distributed and references should be provided for studies that are used to support youth programs. Inaccurate data will continue to serve as a barrier to effective implementation of HIV and STD prevention and treatment initiatives for youth. For example, a study cited in one of the panel presentations on infection rates with HIV prevention tools was flawed in several

areas. The study showed that condoms resulted in an 80% infection rate of HIV after a decade of use. However, no data from any other source have shown that condoms led to even an 8% infection rate per year. Oral acyclovir and vaccines were described as HIV prevention tools in the study, but no data have been published in this area. The study referred to a decade of female condom use, but efficacy data have not been collected in this area for the past ten years. No solid data were provided to support the statement that 75% of persons were infected after a decade of life with no knowledge of the population or discordant couples.

- More emphasis should be placed on reaching high-risk youth in the non-general population. For example, curriculum- or school-based programs would not be effective for AA and Hispanic youth, high school dropouts, homeless youth with no family foundation or youth sex workers.
- Innovative strategies should be developed to reach youth who use the Internet for sex. For example, HIV prevention and other health education materials could be developed and posted on the "My Space" web site, chat rooms and other Internet tools used by youth.

CHAC Business

Mr. Milan informed CHAC that Dr. McGuire would no longer serve as the CHAC co-Chair after the current meeting because her term would expire on November 30, 2006. Dr. Temoshok raised the possibility of CHAC making a formal recommendation to extend Dr. McGuire's term for an additional year due to her ongoing involvement in the Strategic Plan Workgroup and other CHAC activities.

Dr. Fenton clarified that this request would most likely not be honored because Dr. McGuire has served for two consecutive terms as a member and co-Chair. However, he explained that Dr. McGuire could still be involved in CHAC's activities as a workgroup member or external consultant. The participants applauded Dr. McGuire's diligent efforts, dedication and commitment during her outstanding service as the CHAC co-chair.

Mr. Milan entertained a motion to approve the previous minutes. A motion was properly placed on the floor and seconded by Drs. Leoutsakas and Garcia, respectively. CHAC **unanimously approved** the May 17-18, 2006 Meeting Minutes with no changes or further discussion.

Mr. Milan reviewed issues that the members raised during the meeting or suggested to him and Dr. McGuire off-line as CHAC's potential formal motions or letters of advice to the CDC Director, HRSA Administrator or HHS Secretary.

- FY'07, FY'08 and FY'09 budgets for HIV, STD and hepatitis prevention, treatment and care.

- Strategic Plan issues: (1) creation of a coordinated National HIV Strategic Plan with cross-sector and cross-agency resources; (2) a related or separate Strategic Plan for AAs; (3) an additional two-year extension for a five-year Strategic Plan, including annual targets, resource requirements and strategies for AAs; and (4) development of models for resources needed for each year of the Strategic Plan.
- Issues related to CDC's revised HIV testing recommendations: (1) projections of newly-diagnosed HIV cases identified through the new HIV testing initiatives; (2) implementation in both public and private sectors; (3) standardized language or best practices for HIV testing consent forms; and (4) development of HIV testing algorithms for private laboratories.
- Refined projections by HRSA on the current number of PLWH affected by the Medicare Part D donut hole and strategies to ensure continued HIV care for these clients.
- Completion of the HHS clearance process for HECAT.
- STD issues: (1) consistent messages to implement CDC's STD Treatment Guidelines; and (2) future activities and resources by DASH and DSTDP to reduce the number of STD infections in the United States.
- Inadequate funding of the CDC Division of Viral Hepatitis and the need for more resources for hepatitis prevention, C&T and vaccine distribution.
- Response by HRSA, CMS and NIH on treatment and care for newly-diagnosed HIV-positive persons.
- Development of medical protocols by HRSA and CMS for HIV and STD testing and treatment.
- CDC's approaches to resolve problems with PEMS data elements.
- Specific language in the reauthorized CARE Act to allow for a transition period for states that have not converted to name-based reporting systems.
- Recognition of HRSA's outstanding efforts during a time with no reauthorization of the CARE Act.

CHAC extensively discussed the issues Mr. Milan proposed as potential formal motions or letters of advice to the agencies. The deliberations resulted in CHAC making ten formal motions to the CDC Director, HRSA Administrator or HHS Secretary. All ten of the formal motions were properly placed on the floor and seconded by voting members and **unanimously approved** by CHAC.

1. CHAC recommends that the HHS Secretary seek supplemental funding in the FY'07 budget to meet current program needs for domestic HIV, STD and hepatitis prevention, treatment and care.

2. CHAC recommends that the HHS Secretary request FY'08 and FY'09 budget levels for domestic HIV, STD and hepatitis prevention, treatment and care which move beyond historic flat funding levels and provide significant new resources to meet program and domestic needs.

3. CHAC recommends that CDC revise the draft HIV Prevention Strategic Plan with the following changes. The first two bullets under the "summary of recommendations" on page 5 should be deleted. The third bullet should be modified with the following language: "Prioritize racial, ethnic and sexual minority populations as well as demographic groups with disproportionate burden of disease/incidence where funding prioritization is linked to the degree of burden/ incidence. On the basis of current epidemiology, highest priority in implementation of the Strategic Plan should be given to high-risk AAs and MSM within the goals as appropriate."
4. CHAC recommends that CDC extend the Strategic Plan to 2010 and include annual indicators of progress.
5. CHAC recommends that the HHS Secretary take the following actions: (1) The HHS Secretary should initiate the development of a multi-sectoral National Plan for HIV Prevention, Treatment and Care that addresses activities of all sectors and includes all relevant federal agencies. (2) The HHS Secretary should provide CHAC with a status report on progress in developing the National Plan by the next CHAC meeting. (3) The HHS Secretary should request that the President support and impanel a committee to develop the National Plan. (4) The HHS Secretary should meet with CHAC or its co-Chairs on the development of the National Plan.
6. CHAC recommends that CDC develop projections for the number of newly identified HIV-positive persons who might be identified through its new HIV testing initiatives. CHAC further recommends that CDC develop models for financial resources needed to successfully implement the updated HIV Prevention Strategic Plan.
7. CHAC recommends that HRSA continue to refine its estimates of the number of HIV-positive persons who would be impacted by the Medicare Part D donut hole. CHAC further recommends that HRSA develop strategies to support and maintain health coverage for these individuals.
8. CHAC recommends that the HHS Secretary expedite final clearance of the HECAT curriculum for STDs among youth because this evidence-based guidance is a critical need in the field.
9. CHAC recommends that CDC develop projections and models of needed resources for promoting national control of HPV, genital herpes, chlamydia, gonorrhea and syphilis.
10. CHAC recommends that the co-Chairs draft a letter to the HHS Secretary with the formal motions approved during the meeting and a delineation of percent increases for the funding requests.

In addition to approving the ten formal motions, CHAC also took actions to address other issues. CHAC agreed that CDC would complete the development of the goals, objectives and targets in the Strategic Plan. CDC would finalize and distribute the Strategic Plan to each CHAC member no later than March 31, 2007 in preparation of a discussion of the document during the May 2007 meeting.

CHAC identified several items to be placed on the next meeting agenda:

- Progress report by DSTDP on CHAC's formal motion to promote national control of HPV, genital herpes, chlamydia, gonorrhea and syphilis.
- Presentation by CDC and HRSA on prevention strategies with the Internet, text messaging and other technologies that could be used to reach young MSM of color and other high-risk populations.
- Presentation by CDC and HRSA on HIV prevention, care and treatment targeted to Native Americans, Alaska Natives and Native Hawaiians.
- Update by HRSA on the CARE Act.
- Presentation by an HHS representative on the HHS department-wide strategic plan and its relationship to HIV and STDs.
- Overview by CDC on its approaches to generate, collect and utilize surveillance data, particularly information gathered on MSM.
- Progress report by CDC on the ongoing development of laboratory algorithms for HIV testing and confirmation in the context of rapid HIV tests.

Public Comment Period

Ms. Shay Welch emphasized the critical need for federal agencies to gather HIV data in Indian Country. Existing systems do not collect or report HIV data in Indian Country despite the disproportionate and alarming rate of HIV infection. Education and other HIV activities targeted to Indian Country are limited. Tribes have government-to-government relationships and are not captured in federal data sets. American Indians are frequently misclassified in reporting systems. The HIV epidemic is causing a reduction in the overall Indian population.

Ms. Welch urged CHAC, HHS, CDC, HRSA and the Indian Health Service to serve as voices for indigenous people and consult with Indian Country. For example, CHAC and the federal agencies could convene a workgroup of American Indians to obtain feedback on effective and culturally-appropriate HIV prevention, care and treatment strategies for tribes.

Closing Session

Mr. Milan announced that the current proceedings would be the final CHAC meeting in the 25th year of HIV/AIDS. He thanked the members for their continued support, dedication and commitment to PLWHA in the United States. He was extremely proud that the passion, expertise, advocacy and knowledge of the CHAC members have significantly contributed to improving the quality of life of PLWHA. Mr. Milan looked forward to continuing to participate in CHAC's efforts to end the HIV epidemic through prevention and provide service to persons in most need.

The next CHAC meeting would be held on May 7-8, 2007 in Atlanta, Georgia. With no further discussion or business brought before CHAC, Mr. Milan adjourned the meeting at 12:11 p.m. on November 14, 2006.

I hereby certify that to the best of my knowledge, the foregoing Minutes of the proceedings are accurate and complete.

_____ _____

Date

Jean Flatly McGuire, Ph.D., Co-Chair
CDC/HRSA Advisory Committee on
HIV and STD Prevention and Treatment

_____ _____

Date

Jesse Milan, Jr., JD, Co-Chair
CDC/HRSA Advisory Committee on
HIV and STD Prevention and Treatment